

# OJAS AYURVED CENTRE

Please FILL THIS FORM COMPLETELY and send it to our clinic by post at the address given in the end of the form.  
or send as an attachment to our email @ [sarita.vaidya@ojasayurved.com](mailto:sarita.vaidya@ojasayurved.com)

1	Name	
2	Age (Yrs)	
3	Gender	
4	Marital Status	
5	Detailed Address	
6	Tel/Mobile.No.	
7	Email Id	
8	Occupation (Exact Type of Work)	
9	Birthdate and Birthtime (pl provide both)	
10	Present Complaints	
11	Since how long suffering from these complaints?	
12	Past Illness Like Measles, Chicken Pox, Jaundice, Typhoid, Allergy, Any Major Surgery	
13	Are you under treatment right now? For what? Give details	
14	Heredity –Any Major Illness From Maternal, Paternal Side?--- High B.P., Diabetes, Thyroid, Heart Disease, Cancer, Other	
	<b>Your Dietary Details:</b> (Pl explain in details since it is very important for us)	
15	Morning : Tea/Coffee/Milk/Other	
16	Lunch –What Time? Chapatti, Rice, Dal, Vegetable With Gravy Or Without Gravy, Curds, Non Veg	
17	Evening Snacks- Tea/Coffee, Yes/No	
18	Dinner-What Time? Chapatti/Rice/ Dal /Vegetables/Non-Veg	
	<b>Your Food Details:</b> (Pl explain in details since it is very important for us)	
19	Are You Hungry When You Eat Food OR You Eat Just Round O'clock As Per Timing?	
20	Any trouble of digestion?	
21	Are You Vegetarian Or Non Vegetarian? (What Is The Choice In Non Veg— Chicken/Mutton/Fish)	
22	How Much Is The Daily Consumption Of Curds In Your Diet?	
23	How Much Is The Sweet Consumption In A Week?	

24	How Much Is The Consumption Of Fermented Food Like Idli, Dosa, Dhokala, Bread.....In A Week?	
25	How Much Tea/ Coffee You Drink Every Day	
26	How much consumption of cold coffee/ milk shakes/fruitsalads/ice-creams	
	<b>Exercise Details:</b> (Pl explain in details since it is very important for us)	
27	Gym / Walk/ Other – Duration	
28	Sleep/ Disturbed / Sound Sleep—Duration	
29	Any Mental Stress Right Now Or In Recent Past	
30	About Motions <b>Regular/Sticky/Constipation/Unsatisfactory</b>	
31	Urination <b>Frequent/ Nocturnal/Scanty</b>	
32	In Females- How Is Menstruation? <b>Regular/Irregular/ How Is The Flow—Scanty/Heavy/Painful</b>	
33	In Females-How Many Deliveries? <b>Normal/ Caeserian</b> Any Abortions/Miscarriage?	
34	Apart From Above Inputs, Any Other Specific Information—Give Details	

Sent to Following Address:

OJAS AYURVED CENTER  
5, Upendra - 1 Society,  
Opp. Hotel Nisarg,  
Padalkar Hospital Lane,  
Nal - Stop,  
Pune - 411 004,  
Maharashtra, India.  
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